2009 STAFF HEALTH EXAMINATION FORM

Staff Name: ______________________ ☐ Male ☐ Female Birth Date: ______________ Age at Camp: _____

Home Address: ______________ City/State/Zip: ______________ Home Phone Number: ______________

If staff member is under 21 years of age:

Parent Name: ______________ Work Phone Number: ______________ Cell Phone Number: ______________

Parent Name: ______________ Work Phone Number: ______________ Cell Phone Number: ______________

IN THE CASE AN EMERGENCY, PLEASE CONTACT:

1. Name: ______________ Phone: ______________ Relationship: ______________
2. Name: ______________ Phone: ______________ Relationship: ______________

Physician Name: ______________ Phone: ______________

Physician Address: ______________

Dentist/Orthodontist Name: ______________ Phone: ______________

Dentist/Orthodontist Address: ______________

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY)

Name of Contract Holder: ______________ Relationship to Staff: ______________

Carrier Name: ______________ Carrier Address: ______________ Insurance ID Number: ______________

Certificate Number: ______________ Group or Policy Number: ______________ If Blue Cross: BC of (City) ______________

INDIVIDUAL'S CONSENT OR IF UNDER 18, PARENT'S OR GUARDIAN'S CONSENT

1. The information provided on this form is correct and complete as far as I know, and my child has permission to engage in all camp activities except as noted.
2. I hereby authorize the camp director or camp medical staff to act on my behalf according to their best judgment. I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests or treatment, to arrange necessary related transportation for my child and to release any records necessary for insurance purposes. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, anesthesia or surgery for my child. This completed form may be photocopied for trips out of camp.
3. I hereby authorize the release of any information in connection with this form that the hospital or physician in their sole discretion may deem proper.
4. I hereby authorize payment of medical benefits to the camp's designated physician, provider or hospital for ser vices described herein.

Insurance Certificate Holder Signature ______________ **Date** ______________

Parent or Guardian Signature ______________ **Date** ______________

HEALTH HISTORY (General Questions – Explain "Yes" Answers Below)

	Has/Does the staff:	Yes	No
1.	Had any recent injury, illness or infectious diseases?	☐	☐
2.	Have a chronic or recurring illness/condition?	☐	☐
3.	Ever been hospitalized?	☐	☐
4.	Ever had surgery?	☐	☐
5.	Have frequent headaches?	☐	☐
6.	Ever had any serious injuries?	☐	☐
7.	Wear glasses, contacts or protective eye wear?	☐	☐
8.	Ever had frequent ear infections?	☐	☐
9.	Ever been dizzy or passed out during or after exercise?	☐	☐
10.	Ever had seizures or other epileptic symptoms?	☐	☐
11.	Ever had high blood pressure?	☐	☐
12.	Ever had heart trouble?	☐	☐
13.	Ever had back trouble?	☐	☐
14.	Ever had problems with joints (knees, ankles, etc.)?	☐	☐
15.	Have an orthodontic appliance brought to camp?	☐	☐
16.	Have any skin problems (itching, rash, acne, etc.)?	☐	☐
17.	Have diabetes?	☐	☐
18.	Have asthma?	☐	☐
19.	Had mononucleosis within the past 12 months?	☐	☐
20.	Had problems with diarrhea/constipation?	☐	☐
21.	Have problem with sleepwalking?	☐	☐
22.	If female, have an abnormal menstrual history?	☐	☐
23.	Have a history of bed-wetting?	☐	☐
24.	Have an eating disorder?	☐	☐
25.	Ever had emotional difficulties for which professional help was sought?	☐	☐
26.	Other?	☐	☐

Please explain any "yes" answers, noting the number of the questions: ______________

(OVER)

STAFF HEALTH HISTORY (continued)

NAME: ____________________

MENTAL and EMOTIONAL HEALTH INFORMATION: Answer this section referencing the essential functions of the staff member's camp job.

Has/Does the staff:	Yes	No
1. Have an emotional health concern that will impact your work?	☐	☐
2. Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder that will impact your work?	☐	☐
3. Do you have an eating disorder that will impact your work?	☐	☐
4. Do you have a learning challenge that will impact your work?	☐	☐

If "yes" to any questions in this section attach a statement that:

a. Describes the concern and your management plan while working at camp; and
b. Describes the support needed from your work supervisor to complement your plan.

PLEASE NOTIFY US IF STAFF HAS BEEN EXPOSED TO ANY CONTAGIOUS DISEASES DURING THE 3 WEEKS BEFORE THE START OF THE CAMP SESSION.

Which of the following has staff ever had: ☐ Measles ☐ Chicken Pox ☐ German Measles ☐ Mumps ☐ Hepatitis ☐ Sinusitis ☐ Bronchitis ☐ Rheumatic Fever

PLEASE GIVE DATES OF MOST RECENT IMMUNIZATIONS FOR:

DTP	________	Polio	________	Haemophilus Influenza B	________
TD (Tetanus/Diphtheria)	________	Measles	________	Hepatitis B	________
Tetanus	________	Rubella	________		

MEDICATION ALLERGIES (list and describe reaction and management of the reaction): ____________________

FOOD ALLERGIES (list and describe reaction and management of the reaction): ____________________

OTHER ALLERGIES (list and describe reaction and management of the reaction) – include bee or other insect stings, hay fever, asthma, animals, etc.: ____________________

MEDICATIONS – Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Include the name of medication, the dosage and frequency of administration. ____________________

RESTRICTIONS – Please list dietary restrictions, specific activities to be avoided, or necessary adaptations or limitations: ____________________

FOLLOWING MUST BE COMPLETED BY LICENSED MEDICAL PERSONNEL

I have examined the above listed camp volunteer or employee. Date of last examination: ____________

BP: ____________ Weight: ____________ Height: ____________

In my opinion, the above applicant ☐**is** ☐**is not** able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions: ____________________

Current treatment at the time of this report includes: ____________________

Recommendations and Restrictions at Camp:

Any medications to be administered at camp (name, dosage, frequency) or medically-prescribed dietary restrictions: ____________________

Any known allergies: ____________________

Description of limitation or restriction on camp activities: ____________________

Signature of Licensed Medical Personnel: ____________________ Date: ____________

Printed Name: ____________________ Title: ____________________

Address: ____________________

City, State, Zip: ____________________ Phone: ____________________